**Please Print**

|  |  |
| --- | --- |
| Last Name First Middle | Date of Birth |
| Street Address or PO Box | Daytime Phone |
| City, State, Zip | Evening Phone |

**I request that Ocean Beach Hospital provide me with a copy of my health information as follows:**

|  |  |
| --- | --- |
| **Which dates of service?** | Specific: From\_\_\_\_\_\_\_\_\_\_\_\_\_\_ To\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  One-Year History Other:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
| **What information are you requesting?** | Clinical Summary (Provider documentation, medication list and diagnostic information: Lab, Radiology, EKG, etc.)  Radiology Images (Disk)  Other (specify):\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
| **How do you want it delivered?** | Pick up in person \*Only yourself or a Designated Representative  Mail to the above address    Mail to other:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  Other:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
| **Special Authorization** | Records containing information relating to drug, alcohol, mental health, and sexually transmitted disease testing, diagnosis, and treatment or history require special authorization. Please initial the following as they apply:  \_\_\_\_\_:Drug/Alcohol history, diagnosis, and/or treatment  \_\_\_\_\_:Mental Health history, diagnosis, and/or treatment  \_\_\_\_\_:Sexually Transmitted Disease history, diagnosis, and/or treatment |
| *I hereby authorize the release of the medical records specified above. This includes Special Authorization, if indicated above. I understand that once this information has been disclosed, it may no longer be protected by privacy laws and may be subject to redisclosure.*  **This authorization expires one year from the date of signing unless revoked or otherwise specified:**  **Date**  **Signature of Patient or Parent/Guardian/Authorized Representative Date**  **Relationship to Patient** | |
| **STAFF USE**  Records Copied by: Date:  ID Verified  Records Released by: Date: | |

**How to request a copy of your medical record:**

* Complete the attached **Authorization for Release of Protected Health Information** form and mail or deliver to Ocean Beach Hospital
* Please be sure to include a complete address and a phone number where we can reach you, in case we have any questions about your request
* If a parent, guardian, or an authorized personal representative is signing this form, please include your relationship to the patient on the line provided

**IF YOU HAVE A CURRENT RELEASE ON FILE YOUR RECORDS WILL NOT BE AUTOMATICALLY RELEASED, YOU MUST CONTACT THE HIM DEPARTMENT (360-642-6356) AND REQUEST THE RECORDS BE PREPARED**

**What to expect:**

* **Authorization for Release of Protected Health Information** is good for one year unless otherwise stated.
* Your request will be processed within 14 business days once it is received by the HIM department.
* If you are requesting records for a provider we may be able to expedite the release process for continuity of care by having the requesting provider fax a request directly to the HIM department at 360-642-8070
* Your authorization may be cancelled in writing at any time. A cancellation will not change releases that happen before the cancellation
* This release is only good for Ocean Beach Hospital
* Photo ID required when picking up requested records

**Designating a Representative:**

If you want a person besides yourself to have access to request and/or pick up copies of your medical records you will need to complete the **Designated Representative Authorization Form**.

* This form must be completed by the patient and witnessed by Ocean Beach Hospital staff for it to be valid.
* Once the form is complete it is valid for 1 year unless otherwise documented on form
* Your authorization may be cancelled in writing at any time. A cancellation will not change releases that happen before the cancellation
* The Authorized Representative will be required to provide ID when obtaining any records on the patients behalf

**Consent of a Minor:**

A minor patient’s signature is required in order to release information pertaining to following conditions:

* Any Age: Contraception, sterilization, pregnancy, and pregnancy termination
* Age 14 and above: Sexually transmitted disease testing and treatment
* Age 13 or above: Mental Health Information & Alcoholism or drug abuse

Contact Information:

**Ocean Beach Hospital**

**Health Information Management**

**P.O. Box H**

**Ilwaco, WA 98624**

**Phone: 360-642-6356**

**Fax: 360-642-8070**